Editorial.


Articles:

• P. 21. The Reform of Forensic Hospitals in Italy. by Gabriele Rocca. WAPR Dep SecGen.
• P. 27. Internet consultancy program Stopstigma. Pavel Říčan. Centre for Mental Health Care Development, Prague, Czech Republic.

Reports:

• P. 31. WAPR annual meeting with collaboration of LCFT on 16 April 2016. Report prepared by Dr Ramakrishna Manjunath ST4 & Dr Sher Ahmed ST5.
• P. 33. International Congress on Employment and Recovery.
• Murcia, Spain, November 24th-25th, 2016.
• P. 35. WAPR-Iran. Dr Hamid Taherkhani, President; Dr Mitra Khalaf Beigi, Secretary.
• Chiang Mai, Thailand, Rajanogarinda Institute of Child Development.
• P. 43. WAPR in Ecuador. 13-14 Octobre 2016.
• P. 47. WAPR in Colombia; “3rd Conference on the Role of Emotions in the Post-Conflict Scenario”.

Organisational.

• P. 50. Updates from the National Branches. Barbara D’Avanzo.
Since the last report, WAPR’s agenda has been busy in the following issues.

**REGISTRATION AS AN INTERNATIONAL NGO.**
As I announced in Seoul, one of my priorities as President would be to strengthen our structures as an organisation. So, as it was announce in our networks, after many bureaucratic actions, WAPR is finally registered as an International NGO in the Spanish Home Affairs Registry for Associations. This means now we have full legal capacity as an Organisation, including the possibility to apply and receive funding from international donors for our activities. This is an important action that solves a previous vulnerability and gives us the possibility to face one of our pending weaknesses, that is our weak financial structure. Now, after some conversations, we can face the creation of a Fund Rising Committee, with the target of create a more solid way of funding our activities.

**WEBSITE AND SOCIAL NETWORKS.**
As it was announced in Seoul, first Board Meeting of this term, we needed to renew the website. The rapid changes in technology, and the evolution of our structures made necessary to face that project. It was proposed that we would need to create anew site that could be easily managed by us, with latest and full compatible technology, and with the possibility to be easily transferred to another Webmaster when necessary, i.e. when the presidency goes to India next term. Now this has been done. We have a new site, easy to handle, and highly connected with different networks (Facebook, Twitter and Google+). The new site includes some very convenient features. First, a private section for members that requires password, so we can publish documents in restricted area, only for WAPR members. Second a secure payment gateway, so dues can be very easily paid easily, including the possibility of payment with a simple credit card transaction. We expect that this will ease our life in this aspect of our associative life. And third, the updates in the news sections of our site will be automatically published in Facebook, Twitter and Google+. This feature is already active, and our social networks are gaining dissemination and presence. Just as a simple example, the greeting video in the last Mental Health Day had more that 3000 hits.

For reference:
Website: [www.wapr.org](http://www.wapr.org)
Facebook: [www.facebook.com/WAPR](http://www.facebook.com/WAPR)
Twitter: [@wapr_amrp](http://twitter.com/wapr_amrp)

**SPECIAL TASKFORCE FOR WAPR COLLABORATING CENTRES FOR TRAINING AND RESEARCH (WAPR-CCRTs)**
In Seoul, we agreed in the formal creation of a procedure to create new WAPR Collaborating Centres for Training and Research. These centres should be places where some psychosocial attention should be provided in the lines proposed...
by our founding principles - as expressed in the WAPR-WHO Consensus Statement (1996), focusing in the Community Based approach for people with disability linked to some mental condition.

In Manchester Board Meeting, we passed the first one: Psychiatric Rehabilitation Unit, Behavioral Sciences Pavilion, Sheikh Khalifa Medical City – PRU, BSP, SKMC, in Abu Dhabi City, UAE, (contact person, Medhat Elabbahi, WAPR Reg. VP).

Two more proposal have been received and reported in positive terms by the Committee, CoChairred by Harry Minas:

- The Psychosocial Consultation Centre – CAPsi, Icesi University, in Cali, Colombia (contact person: Ximena Castro, Director CAPsi, Professor Psychology Department, Universidad Icesi), and 
- Africa Mental Health Foundation (AMHF), Kenia, (contact Person, David N’Detei, Professor of Psychiatry, University of Nairobi).

Indeed these are good news, and we expect some more Collaborating Centers in the future, was well as reports of activity from them.

COMMITTEES.

Committees are a very important part of the life of WAPR between Congresses. However, we are aware of the difficulty of keeping active committees, I have the expectancy that if we have clear and limited targets, it will be possible to keep some of them active. In this term, the proposal is that the active committees will have the opportunity to present their outcomes in WAPR World Congress Madrid 2018.

My proposal in Seoul was committees to be in narrow connection with the World Congress in Madrid, 2108, so every active committee will have the opportunity to present its outcomes in a special session.

EDITORIAL COMMITTEE.

Under the direction of Marit Borg (Norway), chair of our standing Editorial Committee, the bulletin is being released with regularity. Some other Board Members, as Barbara D’Avanzo (Italy), have been collaborating. It should be noticed that the Bulletin is increasing its quality, and is very informative of the many activities that happen around WAPR and its branches.

We have had some conversations about how to coordinate the management of the website in the Editorial Committee, and we will probably have some agreements in the next future abut this, in order to optimise our coordination and share the workload.

COMMITTEE OF TRAINING, AND GOOD PRACTICES.

Training is one of the most remarkable queries formulated in WAPR meetings in many countries. However WAPR’s structure is still too week as to be able to provide systematic training wherever it is requested, there is something we can certainly do: to agree in a basic training programme in PSR, able to be delivered in a limited time, that would include the basic requirements to work in this field. This project has already been initiated, under the direction of Marianne Farkas (Boston, US), and hopefully will present in Madrid World Congress a consensual proposal.

Other proposed committees.

COMMITTEE FOR SITUATIONS OF EXTREME SOCIAL TRAUMA.

There is an increasing interest in WAPR this kind of social determinant that is living in conditions of extreme social trauma, due to natural disaster or human made conditions. Two of our officers have expressed interest in working in this line within WAPR framework: Alberto Fergusson (Colombia) and Khalid Mufti (Pakistan).

HUMAN RIGHTS COMMITTEE.

This committee is a very important element of our agenda, since HHRR is one of the fields that have received more attention in the last years from several relevant international agencies. Michaela Amering, will be chairing the committee, and has sent a work plan. We are all aware that in our field, in many interventions there is a important risk of collision with HHRR principles, in issues like advocacy and protection, interventions on acute yards, interventions in forensic institutions, guardianship and other forms of substitute / supported decision making, etc. Moreover, the promulgation of the UN Declaration of Rights of Person with Disabilities has received a lot of attentions and some technical discussions. This is why, again, we will pay attention to this important field and will propose a Special Symposium in our World Congress specially dedicated to it.

EARLY INTERVENTIONS.

Early intervention is one promising field in PSR, since it describes the process of the onset of symptoms, explores ways to shorten the lime lapse
until appropriate treatment is established, and if providing research about the best evidence based approached to for treatment. WAPR is aware to the increasing interest in this and Ricardo Guinea will chair a Special Committee about this, focused in organising a special symposium in Madrid WAPR World Congress, 2018.

FORENSIC ISSUES.
Since psychiatry has a role in assessing the Legal system in many situations, forensic issues are in narrow connection with living conditions of many users. Legislation some many countries still need revision (i.e. to adapt to UN Convention of Rights of People with Disabilities). The situation of users under legal measures in connection with mental illness (i.e. forensic mental hospitals) needs attention. Gabriele Rocca, WAPR De. Secretary General, expressed his interest in leading this committee.

FUND-RISING COMMITTEE.
We have discussed that our current way of getting funded will not be sustainable in the mid term. In a situation of economic crisis, Congresses are not likely to provide significative income in the future. Some actions have already been taken. The legal status of WAPR has been issued, since it is already full registered as an International NGO in Spain. So, WAPR will be entitled to apply for funding from donors. In a conversation with our Thyloth Murali, our Pres-Elect we agreed to explore this way.

Other possibilities for WAPR Committees, in connection with WAPR World Congress, can be Housing, Work and Vocational Rehabilitation, Community Outreach Treatment, Users participation, etc. We will be open to proposals for new committees, in connection with the World Congress in the next 6 months. If there is no interest in them, we will forget them.

CONFERENCES.
WAPR has been part (as organiser or as sponsor) in a number of conferences in this term.

- 2016, April, 20-22. Metamorphosis of Mental Health Services: an innovative approaches, 8th Johor Mental Health Convention, Hospital Permai. Johor, Malaysia.
- 2016, May. 25-26; Chiangmai, Tailand.
- 2016, Oct., 7th. II Conferencia sobre las Emociones en el escenario del Postconflicto en Bogotá, Colombia.

WAPR WORLD CONGRESS 2018.
The organisation of the next world Congress has already started. Our President Elect Thyloth Murali (India) has accepted to be Vice-President of the International Scientific Committee. Two mayor organisations in PSR in Spain will be leading the organisation (FEARP, the Spanish branch of WAPR, and AEN-Profesionales de Salud Mental)
The congress will take place in Madrid, in the Palacio Municipal de Congresos, in July, 5-7th 2018. We will be very open to proposals and very keen in participation in all levels. In order to reach a huge attendance, Board Members are kindly requested to help in the dissemination in their countries.

**RELATION WITH WHO.**
WAPR Task force of Action Advocates, has reported WHO about our activities. In the last weeks, we’ve had some communications from WHO, demanding a more structured way of collaboration. We’ve had some conversations within the ExeCom and with Benedetto Saraceno, and we have decided that it will not be a priority to keep our current status with WHO in the conditions of WHO’s new policy. We will remain in good terms with WHO, and in the case we can establish some collaboration in some specific actions, we can always do it.

**NEW MEMBERS.**
We have possibilities for new branches, which are in process of defining their goals and credentialing in WAPR.

**Portugal Branch.**
Filipa Palha, organiser of the conference in Porto (November, 2016) has confirmed interest in it Portugal in creating a WAPR Branch. We are in conversations.

**Chile Branch.**
Meeting in the recent Conference on Community Mental Health in Lima (Peru), October 2016, a number of colleagues from Chile expressed their interest in joining WAPR as a branch, and appointed Carolina Vergara as the contact person. According to our procedures, she can be appointed as National Secretary, with the task of organising the Chile Branch.

**Uruguay Branch.**
After my visit to Uruguay in 2014, the possibility of establishing a branch in Uruguay was considered but we were unable to make progress. Recently, I have renewed contact with Daniel Maltzman, former contact in WAPR, who has offered to establish a branch in Uruguay. Dr. Salzmann is in connection with the National Institution of Human Rights in Uruguay. According to our procedures, he can be appointed as National Secretary, with the task of organising the Chile Branch.

**Ecuador Branch.**
Since our meeting in Seoul, Marius Wolonziej, is advocating for the creation of a section in Ecuador. He was the organiser WAPR Meeting in Santo Domingo de Tsachilas, Oct 2016. He is in close in close relationship with Catholic University in Quito, Ecuador, and working in collaboration with the Vice Chancellor the creation of training initiatives in Psychosocial Rehab there. According to our procedures, he can be appointed as National Secretary, with the task of organising the Chile Branch.

**LINKS**
In Porto, (Portugal) I met Gabriel Ivbijaro, President of World Federation Mental Health. We revised some of our current priorities an agreed in consulting our respective board Boards about joining (WAPR and WFMH) in the call of the 2017 World Mental Health Day, calling attention on the topic of “Mental Health and Work”.

**FINANCES.**
An audited report of 2016 will presented to the ExeCom by the closure of the year.

From the Editorial Committee.
Marit Borg, WAPR Editor.

WAPR is a collegiate organization drawing on a variety of understandings and competencies. Our main resources are knowledge, expertise through lived experience as well as scholarly, generosity, enthusiasm, coordination and synergies. Since its creation in 1986, WAPR has had an impressive expansion. The initial rather small group is now developed to a worldwide organization, credited with significant impact as a global stakeholder, with many national branches, work groups and networks. Some of all this is demonstrated in the present issue of our WAPR Bulletin.

We have reports from the activities of branches in the various WAPR regions. There is a paper about Worldwide grassroots advocacy fighting for dignity in mental health by F. Palha. Another papers offer a presentation of Cooperation between specialized mental health services and general practitioners in Arkhangelsk county, by the authors Rezvy, Andreeva Ryzhkova, Yashkovic, Belay,Popov & Sørlie. The situation of forensic hospitals in Italy is described by G. Rooca in the paper The reform of forensic hospitals in Italy.

And finally P. Rican offers a paper about an anti-stigma action in the Czech Republic called Stop Stigma!

Enjoy your reading!

Marit Borg
Editor
COOPERATION BETWEEN SPECIALIZED MENTAL HEALTH SERVICES AND GENERAL PRACTITIONERS IN ARKHANGELSK COUNTY.

Dr. G. Rezvy¹, E. Andreeva², N. Ryzhkova³, V. Yashkovich⁴, E. Belaya⁴, V. Popov², T. Sørlie¹

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Mental disorders are leading causes of morbidity worldwide with twelve months prevalence rates about 25% in the general population (1). The burden of depression is particularly high and in Russia, there is a particularly high prevalence of alcohol abuse and suicidality (2).

In most Western countries, the general practitioners (GPs) play a central role in both identifying and treating patients with mental health problems as well as in coordinating health care resources within the municipalities and referrals to the specialized services. In Norway, a separate model has been developed for cooperation between community mental health centers (CMHCs) and the municipalities in their geographical catchment areas (3). In Russia, the primary care and the social services are still peripheral in the treatment of people with mental disorders. Here specialized psychiatric services at district policlincs and psychiatric dispensaries in cooperation with psychiatric hospitals still represent the main treatment offer (4). The strong position of specialized psychiatry relate to heavy mental health stigma, a lack of economic resources, and a health legislation barring general practitioners with no specific specialization in psychiatry from diagnosing or treating mental disorders. Previous misuse of psychiatric diagnoses for political purposes has been abolished (5).

During their lifetime, about 80% of the population in industrialized Western countries consults a GP, of whom roughly between 30 and 40% have significant psychological symptoms (6).
However, studies have shown that 30-70% of GPs’ patients with mental disorders remain undetected (7). Barriers preventing GPs to discover mental health problems in routine practice include both individual and systemic issues.

Individual issues relate to personal and professional beliefs and priority setting, as well as the GPs level of adequate training and experience. In addition, patients with mental health problems frequently present with somatic complaints and often prefer a medical explanation of their problems, which often corresponds with the somatic explanatory model of their GPs.

Systemic issues may relate to the high workload in primary care, not allowing for a consultation time necessary for the formation of an adequate treatment alliance and understanding of the situation and condition of the patient as well as limitations for communication and support within a professional network (8,9).

Since 1992, when Russia established a national law on psychiatry, the services have gradually developed in the direction of European standards: decentralizing, strengthening of social psychiatric approaches, incorporating new treatment methods, and integrating psychiatry and somatic medicine (5).

In addition, recent legal amendments seek to enable general practitioners to treat depressive and psychosomatic disorders, diagnose serious mental disorders and follow-up of psychiatric patients after having been treated in the specialized health services.

Formalized Norwegian-Russian international cooperation in the Euro-Arctic Region has taken place since 1993 (10). In Arkhangelsk, psychiatry was regarded as a medical field in which the need for renewal was most prominent. Between 1996 and 2015 six Barents conferences in psychiatry has been arranged, and since 2001, there has been regular project based cooperation on psychiatric health care development between Russian and North Norwegian partners (11). Currently, the Russian-Norwegian project is focusing improvement of mental health care in primary care in the Arkhangelsk region (12).

The relevance of this focus is due to:
• High prevalence of mental disorders and suicidality in the Arkhangelsk region
• The average consultation load of the specialists (psychiatrists and psychologists) at the Arkhangelsk psychoneurological clinic is above the recommended norms and many of those who are in need of psychiatric treatment cannot not be offered treatment here
• In one-third of the districts in Arkhangelsk County there are no certified psychiatrists
• Individuals with non-psychotic mental disorders (the most prevalent mental disorders) are usually first encountered by a general practitioner (GP)
• Mental health stigma may be less provoked in primary than in specialized care encounters
• Poorly developed cooperation between mental health specialists and GPs

Similar factors motivate improvement of mental health care in the primary health care system in most countries worldwide (13).

The quality of mental health care relates to the providers’ communicative, diagnostic and treatment skills, but is also strongly influenced by the quality of professional networks, both in terms of the accessibility of competent coworkers and specialists as well as their support and sharing when the individual provider is caring for individuals with mental health problems (8,9).
Thus, the project is both aiming to improve GPs’ diagnostic and treatment skills, as well as to improve the cooperation between GPs and specialists in psychiatry.

The «Pomor model»

To improve the systemic aspects of psychiatric competence, the project has created and implemented an integrated model for cooperation between specialized psychiatric services (SMS), and primary health care (PHC) (The Pomor model).

In 2011 a small district PHC nearby Arkhangelsk city was selected as a pilot site and the Psychoneurological Dispenser in Arkhangelsk is the SMS.

In order estimate different psychiatric patients’ needs for treatment and care from specialists and GP’s, two samples of patients were examined and evaluated by specialists and GPs: a) a representative group of patients from the psychiatric dispensary and b) patients in primary care with an identified mental disorder.

Based on these evaluations, three groups of patients were identified:

Patients with severe mental disorders with a need for active treatment (18.2%) were a specialist is their primary therapist. When needed, the GP consults the specialists concerning patients’ family relations and social issues.
Patients with moderate mental disorders (47.7%) where adequate treatment can be provided in cooperation between a specialist and a GP through joint consultations.

Patients in stable remission following specialized treatment and patients with mild depression (34.1%) who can primarily be treated and followed up by a GP, if necessary in combination with specialist consultations.

Dividing into these groups has allowed for redistribution of the responsibilities and tasks of GPs and specialists in management and treatment of patients with mental disorders. Consultative support and advice from the specialists increase the competence of the GPs and improve the quality of care for patients with mental health problems.

The project aims to augment the interaction between the GPs and the specialists through the following methods:

Face to face meetings with patient, GP and specialist being present - allowing for shared decisions on treatment goals and approaches,

Face-to-face and telephone consultations between GPs and a psychiatrist/psychologist.

Early information to the GP about patients who are going to be/have been discharged from the regional psychiatric hospital with instructions on initiatives in primary care.

In addition, GPs have received consultation/training on how to provide psycho educational relapse prevention to family members of severely mentally ill patients. The GPs cooperate with the Department of Social Welfare and NGOs on solving social issues when necessary.

The GPs and specialists, who are participating in the project, had a one-week teaching practice at the outpatient unit at a district-psychiatric center (CMHC) and selected primary health care centers in the North Norwegian municipality Fauske.

The GP training has also included systematic diagnostic skills training using a structured clinical psychiatric interview for GPs and training in psychotherapeutic skills based on principles of cognitive therapy.

**Evaluation**

Patient interviews showed positive responses to the cooperation between GPs and specialists, including joint consultations with both a GP and a specialist being present. It is of particular interest to note that patients in stable remission following specialized treatment who were at present followed up by their GPs as well as patients with mild depression who had primarily been treated and followed up by their GP, expressed high satisfaction with their treatment and care. They also conveyed that the experienced level of stigma was lower when meeting their GP than when meeting a specialist at a specialized clinic.

Between 2012 and 2014 the number of patients with mild and moderate depression registered at the PHC increased, mainly due to better psychiatric diagnostics by the general practitioner. In addition, the hospitalization rates from this district to the regional psychiatric hospital decreased, probably due to better continuity of care following discharge from the hospital.

**Progress and further development of the model**

Model development was delayed by lack of cooperation traditions between the GPs and the specialized mental health services, poorly developed financial reimbursement for working with psychiatric patients in primary care as well as lack of professional guidelines for diagnostic and therapeutic work in the primary health care system.
However, despite these limitations, high motivation among the participating health professionals, managers - and especially the active support and recommendation of the Minister of Health, have provided very good progress in the project. The health minister in Arkhangelsk has now decided to implement and evaluate this model in other districts of Arkhangelsk oblast.

In scattered populated areas with long geographic distances between local health providers and available specialists such as in rural Northern Norway and North Vest Russia, the advantages of web-based networking possibilities are increasing. A newly established telecommunication based supervision center at the Psychoneurological Dispenser in Arkhangelsk is used in the implementation of the “Pomor model”.

Specialists who are providing consultations are trained in consultation approaches respecting the treatment responsibility and autonomy of the local provider.

References:


WHO/Europe. What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services? 2004. http://www.euro.who.int/HEN/NewsArchive
World Federation for Mental Health: 
Worldwide grassroots advocacy fighting for 
dignity in mental health.

Filipa Palha (Ph.D.)
Regional Vice-President (Europe), World Federation for Mental Health

**Introduction**

The World Federation for Mental Health (WFMH) has been a leading reference in the mental health advocacy movement since its foundation in 1948. As the only worldwide grassroots advocacy and public education organization in the mental health field, its mission is “to advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health” (WFMH, 2016. Retrieved from http://wfmh.com/index.php/about-wfmh).

In October 2015, the 42nd President of the World Federation for Mental Health (WFMH), Professor Gabriel Ivbijaro, was elected and a very ambitious WFMH Business Plan for 2015-2017 was approved, based on the basic principle of promoting “Dignity in Mental Health”.

In fact, this represents the core value of WFMH, and is the base of all activities the Federation has been promoting throughout the years.

This article will present a brief history of WFMH, and focus on WFMH three main projects: the World Mental Health Day; the Dignity Project and “The Great Push”.

**BRIEF HISTORY**

The history of the World Federation for Mental Health can be traced back to the beginning of last century when Clifford Beers, a former psychiatric patient who had suffered abuse within mental institutions, founded the National Committee for Mental Hygiene in 1910, and the International Committee for Mental Hygiene (ICMH) in 1919.

In 1947, the ICMH agreed to change their name to the WFMH and its original purpose focused on mental hospital reform was expanded to “a new purpose to promote among all peoples and nations the highest possible level of mental health in its broadest biological, medical, educational, and social aspects”.

Note: Most of the content of this article has been adapted from WFMH official documents, and the educational material produced to support 2016 World Mental Health Day activities, and can be fully retrieved from [www.wfmh.com](http://www.wfmh.com).
The Federation is an international membership organization with members and contacts in over 150 countries on six continents. Its organizational and individual membership includes mental health workers of all disciplines, consumers of mental health services, family members, and concerned citizens allowing a concrete collaboration among governments and non-governmental organizations to advance the cause of mental health services, research, and policy advocacy worldwide. The founding principles of the WFMH are reflected in WFHM activities such as the World Mental Health Day, the Dignity Project and “The Great Push that will be now presented.” (WFMH, 2016)

WORLD MENTAL HEALTH DAY

The World Mental Health Day was first celebrated on 10 October 1992 and since then 10 of October has grown significantly to be now considered the world’s most highly recognized global mental health advocacy program, celebrated in many countries worldwide.

The World Mental Health Day is a day for global mental health education, awareness and advocacy, with thousands of supporters worldwide observing an annual awareness program to bring attention to mental illness and its major effects on people’s lives worldwide.

The creator of the idea was WFMH Deputy Secretary General Richard Hunter during Professor Max Abbott’s Presidency. Richard Hunter considered that mental health concerns would be recognized as an integral part of overall health, and he felt that the mission of WFMH was to seek parity for mental health alongside physical health. Since 1994 the WFMH Secretariat developed the concept of an annual theme, with the Federation developing a packet of information, translated into six languages at various times, that can be sent to everyone, free of cost, to allow them to follow the theme in their own way, holding local events.

Throughout the years national and international authorities joined in, organizing large countrywide campaigns for public education, and events have been held in countless cities and countries around the globe. The United Nations, the World Health Organization, the Pan American Health Organization and hundreds of national and international mental health groups are known to have celebrated World Mental Health Day.

According to Franciosi & Abbott (WFMH, 2016), “Richard Hunter and the WFMH saw that an international World Mental Health Day could be, in his words, “a focal point around which global mental health advocacy could gain maximum public attention”. We will continue to work towards the dream of making mental health a priority for everyone, everywhere, by continuing the tradition of World Mental Health Day as one of our signature programs for years to come”.

Filipa Palha, in the UPA Awares ceremony, with Gabriel Ibvikaro, president WFMH and Marcelo Rebelo de Sousa, President Republic of Portugal (left).
2016 WORLD MENTAL HEALTH DAY
THEME: DIGNITY IN MENTAL HEALTH-
PSYCHOLOGICAL & MENTAL HEALTH FIRST AID FOR ALL

This year’s theme for World Mental Health Day was ‘Dignity in Mental Health-Psychological & Mental Health First Aid for All’, which aimed to contribute “to the goal of taking mental health out of the shadows so that people in general feel more confident in tackling the stigma, isolation and discrimination that continues to plague people with mental health conditions, their families and carers” (WFMH, 2016).

The material to support this year’s campaign was developed by WFMH members and many international contributors from all over the globe, including Senior representatives of MHFA, the WHO and members of the World Dignity project. The material was made available globally, free of charge, in WFMH website allowing the Federation to offer to the world something useful to every man and woman in the street. Such capacity re-affirmed WFMH relevance not only to institutions but also to many individuals all over the world.

The importance of mental and psychological first aid to promote dignity in mental health was clearly explained by Professor Ivbijaro:

“At least one in four adults will experience mental health difficulties at one time or the other but many will receive little or no help when they present in an emergency. In contrast the majority of people with physical health difficulties who present in an emergency in a public or hospital setting will be offered physical health first aid. Since the introduction of Basic Life Support (BLS) and Cardiopulmonary Resuscitation (CPR) without equipment in the 1960’s many people have benefitted from the intervention of a passer-by, and lives have been saved. Mental health crises and distress are viewed differently because of ignorance, poor knowledge, stigma and discrimination.

This cannot continue to be allowed to happen, especially as we know that there can be no health without mental health. Psychological and mental health first aid should available to all, and not just a few. This is the reason why the WFMH has chosen Psychological and Mental Health First Aid as its theme for World Mental Health Day 2016” (WFMH, 2016, p. 4).

A “Call to Action” was developed and spread worldwide asking everyone’s contribute to make psychological and mental health first aid available to all as a global priority.

DIGNITY PROJECT

As President-Elect, Professor Ivbijaro embraced a wonderful project, the “Dignity
Project”, resulting on the creation of a symbol that represents dignity in mental health.

As Professor Ivbijaro explained: “every human interaction represents an opportunity for one person to treat another with dignity — a dignity encounter. Individuals and families affected by mental illness can often describe what dignity should look like. Sadly, however, most experience something wholly different. The stigmas of mental illness can no longer be tolerated. We can no longer be bystanders. We must do something.

People with mental health difficulties, their families, careers, governments, NGO’s (non-governmental organizations), professionals of all kinds and the associations that represent them would like all encounters to result in a positive dignity experience. To make dignity in mental health a reality requires every member of society to work together and make mental health visible, not something to be ashamed of. This is what the Dignity Project is all about.

The voice of people with mental health difficulties needs to be heard. There is no health without mental health but there is no single, universally recognized symbol to represent mental health.

Every human interaction holds the potential to be a dignity encounter, an interaction in which dignity comes to fore and may be positive or negative.

The inspiration for a global mental health symbol that represents dignity in mental health has been developed using stories from all over the world provided by people who have experienced mental health difficulties, their relatives and careers.

The International Conference, Mental Health for All – Connecting People and Sharing Experience held in Lille, France in 2015 has provided an opportunity for the World Federation for Mental Health (WFMH), its French Partners, friends and allies to work with a global branding organization, ModelPeople and the Edo Agency to explore the notion of dignity in mental health.

ModelPeople has co-coordinated research that has informed the inspiration for the design for the World Dignity Project working with people who have experienced mental health difficulties, their relatives, careers and friends living in Australia, Brazil, Chile, France, India, Israel, Mexico, Nigeria, Portugal, Singapore, Slovenia, Uganda, United Kingdom and the United States of America.

The World Dignity Project was launched to the general public worldwide in 2016, and aims to identify one million individuals, organizations, countries and states to become Foundation Members by adopting the World Dignity Project Symbol so that we can form a global movement to address the stigma related to mental health” (http://worlddignityproject.com).

Filipa Palha and Ricardo Guinea, meeting with leaders in Mental Health in Portugal, including Gabriel Ivbijaro, President WFMH.
Great Push for Mental Health

The Great Push was founded in 2009 after the many “world reports” concerning mental health had failed to result in action (e.g. “USA Surgeon General’s Report (2000)”, the “WHO World Health Report (2001)”), with the purpose of promoting mental health internationally, influence governments to create change and improve treatment and conditions for the mentally ill.

Vikram Patel, Martin Prince and Professor John Copeland (then WFMH president at the time) met in 2009 to draw up a campaign for action, which resulted in “the Great Push for Mental Health in strategic alliance with the Movement for Global Mental Health” centred on “Unity, Visibility, Rights and Recovery”. The WFMH board approved it as a Federation Programme. The Great Push campaign gathered over 500 organisations from 104 countries in support of the action and reported to ministers at a meeting in New York before the UN Assembly. Those ministers with others then lobbied the UN Secretary-General for a Mental Health Action Plan. The supporters of the Great Push were then asked on what they wanted contained in the Action Plan and sent the results to WHO. The resulting WHO Mental Health Action Plan was very close to what organisations wanted and therefore WFMH could give it full support. What the organisations said they wanted was published as the “People’s Charter for Mental Health” approved by the WFMH Board. The results were also published in the journal “World Psychiatry”.

The Charter defined Five Goals for mental health to achieve: 1. Convening a United Nations General Assembly Special Session for Mental Health; 2. Accepting that the five major noncommunicable diseases affecting world health should include mental, neurological and substance use disorders; 3. That mental health and well-being should be recognised as essential components of the Sustainable Development Goals (SDG’s); 4. Mental health should be represented on all Disaster Emergency Committees; 5. That the WHO Comprehensive Action Plan be implemented expeditiously by all countries.

A further approach to the organisations supporting the Great Push resulted in 417 organisations in 88 countries supporting the Five Goals.

The next most important goal in the Charter is to have a UN Special Session devoted entirely to promoting mental health, which is not an easy goal to be achieved. Some steps are being done in that direction. Last April, an important joint World Bank/World Health Organisation (WHO) meeting was held in Washington DC USA entitled ‘Out of the
Shadows: Making Mental Health a Global Development Priority.

The Great Push project continues working to meet its goals, and welcomes new supporters to join the cause.

As a final remark, the WFMH, as the only worldwide grassroots advocacy and public education organization in the mental health field, has an enormous potential to lead a global movement to promote dignity in mental health. We all know that we embrace a great challenge always hampered by stigma and discrimination. But we believe that one day the world will understand the outrageous individual and social price we are all paying for not dealing with mental health as we do with physical health.

In fact, the message is very simple: “there is no health without mental health”.

References

ARTICLE

THE REFORM OF FORENSIC HOSPITALS IN ITALY
by Gabriele Rocca.
WAPR Dep SecGen

Introduction
In Italy the condition of mental ill people convicted of a crime is changing dramatically. The institutional evolution started some years ago and was founded on two significant events: the Government’s Decree in 2008 and the Parliament’s Committee of Enquiry on Forensic Hospitals which published its report in 2011.

The Decree induced an important change because health care in jails and in forensic hospitals became part of the National Health Service with. Responsibility and funding moved from Prison Administration to Health Companies which manage health care in the different areas of the country. Thanks to this Decree new services and new staff entered the prison increasing the inmates’ right to health.

The Parliament’s Committee wanted to verify the actual living conditions and quality of care inside Forensic Hospitals. After visiting all the Hospitals it rose some specific criticism. A large part of F.H. presented serious structural problems; health and hygienic conditions were unacceptable; the staff was insufficient above all to implement rehabilitative activities; physical restraint was not carried out with adequate procedures and consequently the treatment in some cases appeared damaging to the person’s dignity. The report ended with some guidelines for a comprehensive reform of forensic psychiatry which had to lead to the closing of forensic hospitals.

In 2011 inmates inside Forensic Hospitals were 1378.

The origins
When the enquiry was realized, Forensic Hospitals were 6: Aversa, Barcellona Pozzo di Gotto, Castiglione delle Stiviere, Montelupo Fiorentino, Napoli, Reggio Emilia; women were admitted only in the hospital of Castiglione, but their number was not high.

Forensic Hospitals had been opened between the late nineteenth century and the first decades of the twentieth, the first - Aversa - in 1876, the last - Castiglione delle Stiviere - in 1939, and they were the result of a public awareness campaign of Italian positivist psychiatrists. The new forensic structures “did not reflect a real social necessity in terms of public order or health, or in terms of a hypothetical imperative of social defense” , nevertheless the most
Influential psychiatrists of the time, some of whom were members of parliament, strongly supported the birth of criminal asylums to expand the power of Psychiatry in the judicial field. In 1930 the role of these significant institutions was better defined through the approval of the Penal Code which is still in force and which established the rules for offenders with mental illness. The fundamental criteria to assess them were criminal responsibility and social dangerousness. If an offender was judged by the court not responsible due to a mental disorder and not dangerous to public safety he was released and was cared for in a Mental Health Service. Instead, if an offender is judged not responsible but dangerous to public safety he was admitted in Forensic Hospital. After a period of care the assessment of dangerousness could be made again and could change in positive terms. But if a Department of Mental Health was not available to take care of him, he could remain in the F.H. for an indefinite period. The unavailability of the Departments created a significant number of detentions with no expiration.

It should be noted that the Psychiatric Reform of 1978 established the closing of Psychiatric Hospitals but left unchanged the Forensic ones. So there were two different care systems for psychiatric patients and the difference concerned the institutions where they were admitted and the model of care.

The new law

A few months after the presentation of the Committee’s report in 2011, a new law was passed by parliament. The Law 9 of 2012 modified radically the way of managing offenders with mental disorders and its main points are set out below:

Forensic Hospitals had to end their activity on February 1st, 2013.

People who according to the previous law had to be admitted into Forensic Hospitals, were admitted into new structures named REMS (High-Security Residential Facilities);

REMS have to be small in size, cannot take in more than 20 people and have to provide psychiatric care in a rehabilitative setting;

The staff of REMS is part of National Health Service;

Security and vigilance are ensured immediately outside the facilities with a “perimetral” control;

Each region (Italy is divided into 21 regions) is required to build one or more REMS according to the needs detected;

Patients assessed not to be socially dangerous have to be discharged by Forensic Hospitals and taken into care by Departments of Mental Health: they have to be treated and not detained in hospital any more;

The assessment of social dangerousness has to be made with an individual examination of the patient and not on the basis of social, economic and family conditions;

120 million Euros are allocated for the implementation of the reform.

In summary 3 types of patients can be admitted into new forensic facilities (REMS):

1. Inmates who became mentally ill in prison;
2. Offenders deemed not responsible because of mental illness;
3. Offenders deemed partially responsible because of mental illness.

The implementation of the reform was not easy, particularly regarding the building of new structures. Consequently the deadline was postponed to March 31, 2014 and with another Law - 81 of 2014 - definitively on 31 March 2015.

This entailed an initial planning phase aimed at defining local projects that turned out problematic because Departments of Mental Health for the first time had to treat and manage forensic cases.

Despite these difficulties some specific initiatives have started in Departments and in Forensic Hospitals as the following data can show: inmates in F.H. decreased from 1378 to 826 (September 2014). These patients were assessed according to the possibility of inserting them in rehabilitative programs outside the hospitals: 476 of them could be discharged, 314 couldn’t be discharged and 36 weren’t assessed.

The activity of this first period pointed out some significant themes:

- The geographical criterion for the allocation of patients enabled collaborative relationships between Forensic Hospitals and Departments;
- Thanks to this new partnership several patients were treated outside the institution, in the community and, sometimes, close to their families;
- Some of them moved from Forensic Hospitals to small residential facilities;
- But the increasing presence of these particular patients in residential facilities and in general hospital wards produced critical situations due to the new clinical problems related to the fear of violent behaviour. In other words how to deal with the problem of dangerousness and control of people who were committed to Mental Health Services.
The deinstitutionalization has continued in all Forensic Hospitals: in December 2015 there were only 164 people (Table 1). Furthermore in January 2016 a second hospital (Napoli) was closed and in May the third: Reggio Emilia.

(Table1)

During the same period the Government has played a monitoring role on the activities of Forensic Hospitals. Above all it has had to constantly urge the Regions to build new alternative structures and manage in their geographical areas patients who can be discharged by F.H. This required an organizational and technical effort that each Department has made in its own peculiar way but achieving positive results. So, in September 2015, 404 patients were already admitted into REMS, in December 455\(^2\).

Despite the initial delay the institutional transformation is proceeding in such a way that it’s possible to foresee the complete closure of all Forensic Hospitals in a fairly short time.

The situation in the country doesn't emerge as homogeneous (i.e. the REMS seem to correspond to different residential models) and the timing of implementation of the projects varies from region to region, but the condition of offenders with mental illness is changing in a positive way.

**Conclusions**

Such a complex process has aroused a wide debate with the participation of the various players involved. Many issues have been addressed and many of them are still open; so I would like to propose the most interesting points of the discussion.

- First of all the positive aspects of the reform on which a wide consensus is detectable:
  - the certain closure of Forensic Hospitals;
  - the definition of the structural and organizational criteria of residential structures where offenders with mental disorders have to be treated and controlled;
  - the end of unlimited temporary hospitalizations of individuals who could be discharged;
  - the allocation of funds to implement the reform.

And then some critical points.

- Before this reform Mental Health Services had never taken care people with mental disorders who committed crime. It follows that staff must deal clinical and forensic issues that are not usually covered in the schools of psychiatry and during training courses\(^3\). It is therefore necessary to invest

Mental Forensic Hospital in Aversa, Italy.
rapidly in training programs focused on the care of these difficult patients, and also on the prevention, assessment and management of the risk of violent behaviour.

- Various critics express the fear that small forensic facilities can become mini Forensic Hospitals. This is because it is very difficult to carry out care and control simultaneously and consequently it would be unavoidable to manage patients in the same way in a large or a small institution if structures will have to have this dual function.

- To prevent this risk it's helpful to bear in mind that the heart of the reform is not constituted by building REMS. According to the Law 81 of 2014, Forensic Hospitals must not be replaced by REMS but by all the social and health services in the community. The first aim of the reform, even with these patients, is the care within the various services of Departments of Mental Health. Hospitalization in REMS must not be the first but the last resort, when it's impossible to implement an alternative program.

The law recommends this line of action, yet currently there is a waiting list for admission into REMS.

- The new law established the closing of Forensic Hospitals without changing Penal Code as far as criminal responsibility is concerned, producing a disharmonic condition in the legal field. A radical reform could establish that offenders with mental illness are always responsible and must serve their sentences as the other condemned people. For them, however, it an appropriate treatment must be provided. In this perspective a question arises: how to ensure that a severe psychiatric patient who committed a crime serve his sentence and be cared for?

- Finally we have the issue of the position of guarantee on the basis of which psychiatrists can be judged responsible for criminal behaviours of patients. In the forensic field this trend may be a further confounding factor between care and control, therefore it is necessary to define what the boundaries of this responsibility are.

It's clear that the reform is still in progress. It will be interesting to monitor its evolution by paying specific attention to the outcomes of treatments in new settings and to the impact of the reform on the network of mental health services.
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The Centre for Mental Health Care Development is an NGO based in Prague, Czech Republic.

Its mission is to initiate and implement changes leading to transformation of the existing mental health care system into a community-based system, increase of respect for people with mental health problems, increase of professionalism as well as accessibility of mental health care services.

In 2015, we included a group of peer specialists into our professional internet mental health consultancy service (in operation since 2004). During the project we collaborated with University College of Southeast Norway, Drammen.

**Internet consultancy program Stopstigma**

**How it works**

The consultancy service is an anonymous, non-emergency service provided to the general public. Anyone can ask a question and will get an answer within 7 days. The questioner may choose to get an answer from a psychiatrist, a psychologist or a social worker. (S)he can also request an answer from a peer specialist – in which case (s)he actually gets two answers. All questions and answers are displayed on the website. If the questioner includes his/her personal information, it is removed immediately to safeguard the anonymity.

The professional consultancy team engaged 10 people with experience with mental health issues part-time, most of them having experience from other peer expert positions – working in a mobile help team or giving lectures at universities etc. The peer specialists underwent specialized training in internet consultancy and WRAP (Wellness Recovery Action Planning) as part of the project in order to receive further support in their role. They participated in the planning of the details of the teamwork since the beginning. The peers decided to work in pairs so that they can briefly consult the formulation of the answer. The peer answers were subject to approval of one of the professionals on the team. The answers were discussed afterwards during regular meetings of the whole team.
EXAMPLE FROM STOPSTIGMA.CZ:

Inquiry:
“Hallo,
I was diagnosed as a borderline personality. Sometimes I feel I hear voices, not quite in my head, more as if they were inserted into my head, into my thoughts? I am not sure if this is common or if I should talk to my psychiatrist about it? Thank you.

The professional answer:
Borderline personality patients can experience symptoms similar to those of a psychosis as well. The symptoms are usually shorter term and less intense than schizophrenic symptoms. A more extensive examination would be required in order to clarify the situation and make sure that the diagnosis is accurate, so it is important for you to share this information with your psychiatrist. Generally speaking, the psychiatrist needs to know as much as possible about the patient’s problems so (s)he can help them effectively.

The Peer’s answer
“Hallo,
To be honest, I also hear voices sometimes. It happens especially at times when I am tired or exhausted. At times like that I can hear noise, singing, music or unclear voices. Many people hear voices while falling asleep.
According to the research available to the support network „Hearing Voices“, this phenomenon applies also to a large number of people who do not suffer from any mental illness. Nevertheless hearing voices is considered a typical symptom of schizophrenia. I would certainly share this information with my doctor.
I am aware of the „inserted thoughts“ concept. A few of my acquaintances mention experiencing these but I do not know what their diagnoses are.
The important issue is also what these voices are saying“. If they are not attacking you, you can try to understand them. A good therapist would be able to help you with this.
Evaluation methods:
After the first 8 months of operation we evaluated the pilot project using several methods. The content of the questions was categorized manually to get a basic overview. Short online questionnaire based on INSPIRE was constructed to receive feedback from the questioners. We also organized a focus group with peer counsellors to understand their views.

Results
There were 152 questions asked during this period and 45 feed-backs were obtained. This number is clearly too small to receive statistically meaningful results, nevertheless we formulated several hypotheses about the service.

In 61% of cases, the peer specialists were requested to answer the question in addition to the professional.
In 73% of cases, the questioners were people experiencing mental health problems asking for themselves – in the rest of cases, family members, friends and others were asking on behalf of people experiencing mental health problems.
The content of the questions is categorized bellow: (Fig 1)

The topic of suicide was discussed in 8% of cases even though it was clearly stated that the service is not intended for people in mental health crisis needing urgent care.
Preliminary results below show very high scores obtained through on-line feedback questionnaire. It appears the provided help was considered very comprehensive and respondents felt heard and respected. The qualities of support and hope were rated as slightly less satisfactory.

(Fig 2)
The peer answers were more appreciated by people who asked about their own situation rather than on behalf of others. We came to an overall conclusion that the combination of answers by a professional and a peer consultant provides the client with a more valuable and comprehensive response.
The peer counsellors also reported that this work was beneficial for them. It appeared that working in couples was really a good idea – support in formulating the answers was provided mutually and it was satisfying and assuring. The peers took the job very seriously and benefited from looking for additional resources in literature, as well as amongst friends while trying to provide the best possible answer. They requested further training on topics such as spiritual emergence in the future.

Discussion
The inclusion of peer counsellors into the web based consultancy service seems to generally add value to the professional answers, with a few exceptions where rather technical information was requested. We tried to involve people with lived experience to an area that is traditionally reserved for professionals. The results were very promising. The question is whether the involved peer specialists have the capacity to handle more inquiries and also what further support would be beneficial to them. The evaluation methods seem to be effective but we will need to further evaluate the added value of the involvement of the peers in the program after a longer period of time and with more data at hand.
WAPR annual meeting with collaboration of LCFT ON
16 April 2016
Report prepared by Dr Ramakrishna Manjunath ST4 & Dr Sher Ahmed ST5.

World Association for Psychosocial Rehabilitation (WAPR) is an international non-government multi-disciplinary professional organisation having its members as psychiatrists, psychologists, nurses, social workers, occupational-therapists, policy makers, consumers and their relatives.

WAPR was established in 1986 in France, when about 100 professionals from 35 countries met at its launching congress. Today, the WAPR is recognised as an NGO with consultative status with the WHO, the United Nations (UN) Economic and Social Council and the International Labour Office. It also maintains relations with the European Commission and the African Rehabilitation Institute.

WAPR’s acknowledges the importance of preventing and reducing social disability in long-term community care of people with mental disorders. Towards this agenda, the primary aim of the WAPR is dissemination of principles and practices of psychosocial rehabilitation.

WHO defines psychosocial rehabilitation as a process that facilitates the opportunity for individuals impaired, disabled or handicapped by a mental disorder to reach their optimal level of functioning in the community. This includes both improving individual’s competencies as well as introducing environmental changes in order to improve their quality of life.

The UK branch meeting of WAPR was held on Saturday 16th April 2016 at The Lantern Centre, Vicarage lane, Preston. The meeting was co-hosted by Lancashire Care NHS Foundation Trust. The topic of the day was “Recovery in the Community”. The gathering was attending by various professionals from different parts of the country.

Dr S H Quraishi, Consultant Psychiatrist, Chair WAPR- UK branch and Deputy Vice President WAPR-Europe welcomed the audience and the speakers for the day. In his speech, Dr Quraishi emphasised the importance of multidisciplinary approach in recovery and invited disciplines from other specialities to be members of the WAPR.

Prof Tierney-Moore, Chief Executive Officer of Lancashire Care NHS Foundation Trust inaugurated the conference. She spoke about her experience whilst working as McMillon breast cancer care nurse noticing the interplay between mental health and
physical health realising the importance of adopting holistic care. Prof Tierney-Moore stated supporting families affected with psycho-social needs of any illness brings serious challenges. She highlighted the importance of engaging the carer and addressing patients fear and anxiety as essential features of recovery.

Prof Max Marshall, Medical Director chaired the 1st session, and other two sessions were respectively chaired by Dr M Adelekan and Dr L Leroux, Consultant Psychiatrist’s at Lancashire Care NHS Foundation Trust.

Prof R Raghavan, Professor of Mental Health, Mary Seacole Research Centre, De Montfort University, Leicester lecture was on “Mental Health Recovery for People with Intellectual disabilities: Facts and Fiction”. He stated given the increase in prevalence of mental health needs in people with intellectual disabilities it is important to consider how the recovery approaches could benefit practice within mental health services for people with intellectual disabilities. His presentation explored the similarities between principles of recovery and the current service approach for people with intellectual disabilities.

Helen Lynch, Lisa Smith and Ken Levins from the Lancashire Community Restart services spoke about the importance of social activity in engaging patients with mental health problems in the community. The informed the audience about the “Hub and Spoke” model in Lancashire, which supports service users with housing, employment, faith, volunteering, sports and leisure activities. In addition rural development programme called as the “Open gate project” also provides opportunities in gardening and horticulture.

Miss Valerie Minns, a service user’s carer gave a perspective on how the austerity has changed the carer role. She also stated under the provisions of The care Act 2014, there is a statutory duty on the part of the services to give carers the information they need.

In the post-lunch session, Prof Rob Poole, Professor of Social Psychiatry at Bangor University gave the audience the findings of his research studies on long term care needs for serious mental illness patients in England and Wales. He pointed that NHS spends large amount of money on inappropriate private care in the system of rehabilitation that lacks coordination. Prof Poole also expressed his displeasure on service managers focussing on containment due to their main measurable outcome been SUI and this hindering the prospect of a patient obtaining rehabilitation. He raised the question on what can psychiatrists do to nurture evidence based policies?

Dr J.S. Bamrah, Honorary reader at University of Manchester and Medical Director at Manchester Mental Health and Social Care NHS Trust gave an interesting talk on Confidentiality, Duty of Candour and Duty of Disclosure. He highlighted the importance of confidentiality and that this is central to trust between doctors and patients. However appropriate information sharing is essential for provision of safe and effective care both for the patient as well as the wider community. Examples of case studies and clinical situations relating to ethical dilemma/challenges created a stimulating discussion among the audience.

Close of the meeting along with note of thanks was delivered by Dr S H Ahmad, Consultant Psychiatrist with LCFT.

Details about WAPR, its activities, latest bullets and membership information can be found at its website: www.wapr.info
On November 24th 25th, in Murcia, Spain, took place the I International Congress on Employment and Recovery and Employment, in coordination with the I Fair on Inclusive Employment.

Accessibility to work has been identified as a paramount target in helping citizens with mental illness to achieve a inclusive life, to live independently, to gain a health self image. Accessibility to work is one of the main opportunities we can grant as a mean to recover from mental illness. In the last 20 years a great amount of experience has been accumulated about how to provide the best work opportunities for users, how to provide support to users in workplaces, and how to set the rights stimulus to companies in order to create inclusive an accessible workplaces for users willing to work. The conference offered a framework to a great number of participants from different sectors (professionals, users, carers, employers, managers in companies) to share views and experiences.

European Union, the Region of Murcia and the Murcia Service of Health with collaboration of WAPR and FEARP, the Spanish Federation of Health sponsored the congress.

The main organisers of the meeting, Luis Pelegrin and Jose A. Peñalver, succeeded in organising a very well attended meeting, with free access to all attendees, users, family members and professionals.

The conference received the main representatives of professionals in the psychosocial rehabilitation services in Spain, including Ricardo Guinea, WAPR President, Jaime A Fernandez, President FEARP, the Spanish branch of WAPR, Nel Anxelu, President Confederation Salud Mental, Spain, and David Taroncher, President Asociacion Valenciana de Rehabilitation Psicosocial, and a long list of relevant stakeholders in Spain, Alina-Maria Seclu, from European Social Fund.

The conference included 8 sessions with participation of more than 40 speakers.
Employment is one of the main tools to normalisation and integration in Psychosocial Rehabilitation, and this conference reviewed the current trends in services in support of mentally ill persons willing to work. The fair showed an impressive panel of working experiences in the region, in many different areas, and also from different parts of Europe (i.e. Slovenia, UK or Sweden). The meeting also granted a number of recognitions to different companies that have helped in including mentally ill workers in their professional staff.
We are pleased to inform that Iran WAPR had various activities in 2 recent years. Following the brief report of our activities from 2013 to now is provided:

Holding the quarterly meeting with other Iranian mental health NGOs and trying to share our activities among each other. These meetings had a strong effect on the quality of the services provided by that NGOs, as they received much useful information about the available resources and facilities in their context.

Providing scientific sessions at some universities in various occasions (e.g., international day of schizophrenia, international day of mental health, international day of occupational therapy and so on).

Collaborating with other organization, like Ministry of Cooperative, labour and Social Welfare, Welfare organization and so on. During these meetings, we started to revise the Iranian mental health act and to follow payment insurance. Moreover, we tried to pursuit the potentially of services providing by non-mental health organization.

Holding national and regional festivals for mental health clients, as sport and music festivals. We emphasized heavily on the quality of these programs and are trying to increase the number of these programs in next years.

Holding a session with the president of WAPR, Dr Javed in 12th October, 2015 in Tolo Center of Psychiatric Rehabilitation. During this session, Iran WAPR described its activities and services. Also, members talked about their concerns and plans with Dr Javed and received many positive feedbacks and useful comments from him.
Meeting between the president of WAPR, Dr Afzal Javed and IRAN WAPR members (Iran, Tehran, 12th Oct, 2015)

The National Sport festival (Iran, Tehran, 8th October, 2015)
Johor Mental Health Convention is one of a prominent mental health convention in Malaysia. The convention is being organized by Hospital Permai, Malaysia since 1998. Over the years, it gained more interest among the mental health personal either local or international. It also has successfully collaborated with multiple local and international teams, i.e., International Mental Health Collaborating Network (IMHCN), Eating Disorder Team, National University of Singapore, Monash University and Newcastle University.

The theme for the coming Johor Mental Health Convention was Metamorphosis of Mental Health Services : An Innovative Approaches. The topic was chosen to reflect the changes, evolution and transformation of evidence-based mental health services.

The meeting was very successful and included training workshops, dealing with new approaches to Psychosocial rehabilitation in the region.

DR. Abduk Kadir Abu Bakar.
Director Of Hospital Permai, Malaysia.
WAPR South East Asia.
WAPR South East Asia.

WAPR in the 4ª CDMH Meeting.


Chiang Mai, Thailand, Rajanogarinda Institute of Child Development

Under the initiative of Dr Pichet Udomratn, WAPR and Psychosocial Rehabilitation had a outstanding presence in the 4ª CDMH Meeting, that took place in Chiang Mai, Thailand, organised by Rajanogarinda Institute of Child Development; Department of Mental Health, Ministry of Public Health, Thailand.

The meeting was supported by Department of Mental Health, and Department of Thai Traditional and Complementary Medicine, Ministry of Public Health, Thailand and co-sponsored meeting by World Association for Psychosocial Rehabilitation (WAPR), WAPR, Thai chapter, and World Psychiatric Association (WPA Section on Psychiatric Rehabilitation).

The meeting presented a panel of interventions, covering different aspects of the Mental Health: from the perspective of community mental health and Psychosocial Rehabilitation, form the perspective of the attention of children with developmental disturbances, and also, interestingly, form the perspective of the traditional Thai medicine.

Dr. Guinea, WAPR President, was honoured with the invitation to present the keynote lecture: Psychosocial Rehabilitation Across the Life Span: Global Knowledge and Local Wisdom”, and presented a general overview of the PSR principles, and some introductory notes to some of the main new conceptual trend; the recovery perspective, the early attention

Dr. Pichet Udomratn, WAPR Regional VicePresident, presented a paper about, Positive Psychiatry and Psychiatric Rehabilitation. In his presentation, both concepts of positive psychiatry along with, recovery – oriented practices were reviewed. Implementation of recovery practices require a comprehensive approach including; a positive psychiatry approach, that benefits from the involvement of a multidisciplinary team and / or the greater community.
The traditional wisdom –including some indigenous wisdom- was represented by a number of presenter from Thailand, India or Miamar, who introduced the perspective of Yoga, Meditation and other forms of local wisdom, including some attempts to find integrated models.

The community perspective was well represented by interventions that described the real situation in Thailand and Malaysia, in terms of opportunities to access attention for the mentally ill and the remaining gaps.

The conference was attended by a nutride international audience.
The nice country of Sri Lanka hosted the Asian Federation of Psychiatry (AFPA) Meeting. WAPR participated with the Symposium, “Rehabilitation in the 21st Century” with the following presentations:

- “Integrating the care for Long-term mentally ill to mainstream mental health services”. Nalaka Mendis, presenting a vivid overview on the history of Psychosocial Rehabilitation, in Sri-Lanka.
- Ricardo Guinea contributed with the presentation, “Psychosocial Rehabilitation 2016: State of the art from a global perspective”.
- In the presentation “Burnout and secondary traumatisation: Helping the helpers”, Solomon Rataemane elaborated the topic of how working under extreme circumstances that may affect the staff.
- Other presentations were: Training and developing non-professional task force for psychosocial rehabilitation of mentally ill in Asian subcontinent, by Vyjayanthi Subramaniyan and Community Mental Health Centre as agent of

Presentation “Burnout and secondary traumatisation: Helping the helpers”, by Solomon Rataemane.
change: what is its impact after a year, by Haslina Yusof.
Norman Sartorious offered a pre-congress Workshops on “Leadership” for young psychiatrist”, and a conference on “Economy, Health and Mental Health”, in which presented a realistic vision on the transformation of the psychiatric attention in recent times, its problems, challenges and possibilities”.

In the presentation “Promoting the mental health and human rights of women and girls in adversity” Helen Herman presented a vision on the gender perspective of the mental Health of women, and in particular their exposure to many adverse role dependent social determinants. and its impact in mental health morbidity.
Afzal Javed presented “Recovery & psychosocial rehabilitation: Current updates”. In his turn, Nalaka Mendis presented a vision on the History of Psychosocial Rehabilitation in Sri Lanka, in which he and other WAPR senior officers have had a great participation.
Nirosha Mendis offered to the WARP Delegation a warm reception in the NCMH Colombo, with participation of professionals and carers.
As the result of initiatives of our local contact and National Secretary for Ecuador, Mariusz Wolonziej, WAPR had a full agenda of contacts on its visit to Quito, Ecuador.

First, a meeting with Dr. Nelson Rodriguez, the Vice Chancellor, Central University of Ecuador, to introduce WAPR to the academic environment in the country, and to explore future synergies. As the result of the meeting, some plans were considered, in particular, the interest in an international agreement in training curricula.

Second a meeting in the Ministry of Health, Dep. of Mental Health, to learn about the current situation in Ecuador and to explore opportunities of figure collaboration. As a result of this meeting, we agreed a training teleconference meeting with different professionals in Ecuador, that ill be celebrated in the next weeks.

Then, in collaboration with the Pontificia Universidad Catolica de Ecuador (PUCE) in Quito, Ecuador, we had a full training day with participation of ten relevant professionals in Ecuador, including Marisuz Wolonciej, our National Secretary in Ecuador, Fr. Marco Zsimanski, Chair in the programme “Buena Vida” in Santo Domingo, Iusra Jalkh, former officer in the Health Ministry in Ecuador, and more.

The conference included some brainstorming in order to identify barriers to future development, and next steps in activities in Psychosocial Rehabilitation in Ecuador, including the next creation of the Ecuador Branch of WAPR.

In the meetings, some issues were identified in Ecuador as mayor psychosocial challenges in Ecuador. First, the traumatic results of the big earthquake in past April, that caused more that 600 dead, and a big number of injured. Second, the economic crisis related with the low price of oil that caused the reduction of many programmes that had been initiated. Third, the outstanding importance of violence in connection with substance abuse, including violence in the families, and against women, that represents a very important cause of social stress, and subsequent mental dysfunction (suicide, PTSD, depression, etc.). All stakeholders also identified the absence of a Mental Health law as a barrier for further developments.

The agenda of the visit to Ecuador was very successfully and I wish to that Mariusz Worlziej, Iusra Jalk and Fr. Marcos Szimanksy and PUCE for all the kind arrangements that resulted in no cost for WAPR for these activities.

Ricardo Guinea.
Meeting in Catholic University in Santo Domingo de Tsachilas, Ecuador.
Regional Conference in Community Mental Health. Lima (Peru).
October 10th. 12th. 2016.

Ricardo Guinea presented on the topic of “Training in PSAR, in a context of change of paradigm”. WAPR organise also two special Symposia, with participation of delegates form Mexico, Uruguay, Spain, Venezuela, Nicaragua, Chile and Brazil.

Under the presidency of Mauricio Gomez (Chile) a panel integrated by very relevant leaders and stakeholders of the Mental Health movement (users and family members) from Peru, Argentina, Chile, Brazil, Spain, including family members, and users from different neighbour countries presented a very vivid portrait of different situations, i.e. the way families organisations from Argentina have been contributing in different ways for the improvement of the situation there; or the problems found in real assistance in different environments.

As it happens with increasing frequency, violence as a social determinant received a special attention by Maria Edith Baca, PAHO officer in Peru. The conference also included meetings with carers and some exploratory actions to create a Professional Association, perhaps the nucleus of a future WAPR Peru Section.

Under the organisation of MINSA in alliance with Foundation Manantial and Pontificia Universidad Católica de Peru, and the participation of WAPR, OPS, and other organisations, took place the Regional Conference in Mental Health, October 10th, 12th.

The conference was opened by Dr Yuri Cutipe, main responsible for Mental Health of MINSA (Health Ministry in Peru).

This conference had a special meaning for WAPR, since it is in part the result of a previous exploratory visit of a WAPR Delegation in 2014. After that, Francisco Sardina, WAPR Board Member and Fundación Manantial, (a Spanish foundation) have been exploring collaborative actions, with very important results: many training actions for professionals in Peru, a number of training grants in Spain, and the definition of a collaborative framework, in the perspective of an important psychiatric reform, that will create more than 20 new Centres for Psychosocial Attention.

WAPR had an outstanding participation, with participation of several representatives, Ricardo Guinea, WAPR President, in one of the keynote conferences, Francisco Sardina, Board Member Representing Families, Anel Garcia (Mexico), Ana Pitta (Brazil), Board Members. WAPR organised a videoconference participation of Alberto Colina, WAPR National Secretary for Venezuela.
Miguel A Castejon, working with family carers in Lima, Peru.

Francisco Sardina (left) in one of WAPR Workshops.
Under the Leadership of Alberto Fergusson, WAPR VP, and Miguel Gutierrez, National WAPR Secretary for Colombia, took place in Bogota, Colombia, the 2nd. Conference on “The role of emotions in the Post-Conflict Scenario” co-organised by University of Rosario.

The topic of the Conference had a special meaning in Colombia, since the country itself was at a very emotional moment since the Government had just signed an agreement with leaders of one of the Colombian Guerrilla Movements, that promised a very important step towards the resolution of a political conflict that had lasted more than 50 years, with a huge mass of people affected in different degrees by psychic trauma, forced displacement, kidnapping, wounded or dead by violence from any of the different parties in the conflict.

The conference, celebrated just one day after the unexpected non-endorsement of the political agreement in plebiscite by the Colombia population, had a very special an emotional meaning for all the attendees.

Alberto Ferguson and Miguel Gutierrez presented a theoretical elaboration on the role of emotions in the local political scenario, where strong feelings like forgiveness, retaliation, expectancy, and anxiety were clearly strong factors of the decisions and actions that the whole country was living. Frank Pearl, a representative of the negotiating team from the government of President Santos, offered a vivid report of the process of negotiation, and a political analysis of the scenario after the plebiscite.

Ricardo Guinea elaborated over the role of trauma in psychopathology, the impact oh massive...
social trauma on the population, and the challenge for the country’s social and health systems to tackle it, with special stress in the paramount importance from the perspective of the mental health of the population of making all possible efforts in preventing the continuation of the traumatic situation.

The conference received the contributions of a philosopher, survivor of different adversities in the conflict, and of a student of philosophy who presented an interesting analysis of the situation.

It is interesting to underline that WAPR Colombia has been making interesting contribution in assessing the impact of trauma in the population.

The next two days, WAPR Colombia organised two meetings in University of Rosario, with students and supporters of WAPR, to present the current state of the art in PSR and to do some brainstorming about the next steps in WAPR Colombia.

In a teleconference, Ximena Castro, the Academic Director of the “Consultorio de Atención Psicosocial” in Cali, (www.icesi.edu.co/capsi/) described the organisation of the services and the barriers detected for further developments.

The need to work in a wider dissemination and of improvement the connection with service providers were identified as next steps in WAPR Colombia.
WAPR Africa region.

“Mental Health and Development”.

Under the organisation of (EAA and AAPAP), Addis Ababa hosted the conference (Mental Health and Development”.

Quoting Dr. Solomon Teferra, Chair of EAA, “The African continent has long been ravaged by predominantly man made misfortunes such as protracted civil wars, displacement, rape, torture, dictatorship, massive corruption and extreme poverty; and natural disasters such as draughts floods which all affect the mental well-being of the citizens who live in different countries of the continent. Considering all these predicaments, the continent was once dubbed hopeless and dark with no prospect of improvement. A surprising paradigm shift has happened recently in the fields of economic growth, the image of Africa has started to change from being hopeless and dark to a new growth pole of the world, changing its name to description reflecting hope; the “Africa rising” narrative has replaced the long hold view of hopelessness and stagnation”.

An international group attended the conference from many different countries of sub-Saharan Africa, with also a significant foreign presence, including WAPR Afzal Javed and Ricardo Guinea. Solomon Rataemane, who co-chaired the conference as the President of AAPA, stated that “the theme Mental Health and Development as implies that the provision of mental health services cannot be done in isolation from other developmental need of the countries, including impediments to development such as poverty, lack of specialist human resources, and basic infrastructure to deliver human, accessible and affordable care to the mentally ill.” Beyond, Dr Rataemane proposes that “to achieve balanced an sustainable mental health care to all, we have to propose our own, country initiated and relevant research in mental health, develop multi team interventions involving Psychiatrists, Nurses, Psychologists, Social workers, parents, teachers and governments”.

The conference was served by a number of keynote presentations; Psychosocial Rehabilitation across the live span: Global Knowledge an Local Wisdom (Dr. Ricardo Guinea), Psychosocial Rehabilitation in the XXI Century, Needs, Opportunities and challenges (Dr. Afzal Javed) Poverty and Mental Health (Prof. Crick Lund), Global mental health and neurosciences (Prof. Dan
J. Stein), Burnout and Secondary Traumatisation (Prof. Solomon Rataemane), and Implementing and Updating mhGAP: lessons learned and reflections (Prof. Martin Prince).

Two Symposia were presented with two very relevant topics: Integrating mental health into primary care in Ethiopia, what is the evidence telling us? and Overview of the Programme to Improving Mental Health Care (PRIME). Regarding the first topic the main results presented were that “the health facility level intervention is based on the WHO mhGAP Intervention Guide packages, adapted to the country and restricted to priority mental health conditions (depression, including paternal depression, alcohol use disorder, and psychosis, with epilepsy included additionally in Ethiopia, Nepal and Uganda. The results of the preliminary assessments indicate that the provision of mental health care through fully integrated care provision is a real possibility and remains the only viable approach to provide mental health care for most people with mental illness in LMICs, however careful planning and engagement, anticipating and addressing potential barriers are crucial steps if integrated care is to be a reality. Primary based-care was considered a positive development, and would increase availability, accessibility and affordability of treatments.

Markos Tesfalle, WAPR Representative in Ethiopia and Ricardo Guinea.
WAPR is now a large and global reality with many old and new branches. In the framework of psychosocial rehabilitation as a right for all the persons in need of support in all countries, different activities are provided according to the local degree of achievement of human rights and available treatment facilities. The situation for citizens with mental distress varies following the extension and robustness of community networks, strength of the rehabilitation and recovery culture in services, education facilities and mental health policies.

We intend to give short pictures of the activities of the WAPR branches all over the world, with their differences and similarities, in order to help exchange and collaboration. They will be synthetic and will point out to major activities, main issues and - why not? - difficulties and worries inside the WAPR branch and in the country.

In this issue, we present brief reports from several countries: Colombia, Paraguay, Spain, Italy, Iran. They usually concern the period 2015-2016. Owing to editorial reasons, some reports may not be updated and may refer to end of 2015 or beginning 2016.

**WAPR Colombian Branch**

WAPR Colombia branch was officially launched on Thursday, 27th September 2015 at an impressive ceremony held at Rosario University, Bogota, Colombia. The event was part of a conference organised by WAPR in collaboration with Rosario University, Bogota. The theme of the meeting was “Peace & Post Conflict reconciliation”. Speakers included Maria Victoria Uribe, Fredy Cante, Miguel Gutiérrez, Afzal Javed and Frank Pearl (negotiator in the peace process with Colombia’s guerrilla groups) who gave a very detailed account of psychosocial needs during the post conflict periods and proposed plans for psychosocial rehabilitation of the affected individuals.

A formal meeting of the WAPR branch was held the following day, in Bogota, Colombia. Miguel Gutierrez, who was appointed as the first National Secretary of the branch, discussed various objectives and agreed to start working on enrollment of new members and also planning some activities in the near future.

In the final months of 2015 and first months of 2016, the Colombian Branch and the Psychosocial Investigations Center (CEPSO) of the Universidad del Rosario have been stressing alliances with the Agencia Colombiana de Reintegración, ACR (Colombian Agency for Reconciliation) working as a think tank for difficulties faced by the agency regarding mental health problems in former members of guerrilla and paramilitary groups who are starting a process of reconciliation. We held meetings with former members of guerrilla and paramilitary groups. These meeting gave a great input for the intervention programs we are designing and which are starting to be implemented. We look forward to an important participation of WAPR in the psychosocial
interventions derived from the peace process being held between the Colombian Government and the FARC guerrillas.

(Received from Prof. Miguel Gutiérrez-Peláez, Rosario)

**WAPR related activities in Paraguay**

Paraguay has no official branch, but has relationships with the WAPR through a contact person, Eva Insfran, occupational therapist and director of the Centro de Rehabilitacion Psicosocial “El Puente”, in Asuncion. She is doing her best to keep informed about WAPR a small group of colleagues and co-workers, without being an organized group yet.

Psychosocial rehabilitation is not common in Paraguay. Barriers to its implementation come also from the lack of a mental health network and a sufficient asset of different levels of intervention. No rehabilitation centre exist outside the urban area of Asuncion.

In the El Puente is an exceptional reality: about 60 users are seen every week, mostly former patients of the Psychiatric Hospital of Asuncion. They participate in different group activities, according to their personal needs and interests. There are psychologists, users and family groups, strengthening the courage to participate in social events. Psychoeducation is continuously offered to users and their families.

Since the last two years, Paraguay has been working to more inclusive policy and legislation aiming at education and employment for disable people. Some users have been applying for training, internships or jobs. But there is a long way to go until professionals, families and society will consider this as a routine possibility for persons with mental disorders.

In September 2015 these experiences and ideas were shared with the participants of a psychiatric congress in Asuncion. Also in September 2015 a group of our users took part in a Festival of Art and Mental Health in Argentina.

(Received from Eva Insfran, director of El Puente, Asuncion)

**Iran WAPR**

Iran WAPR has taken part in some various activities during the last two years.

In particular:

holding the quarterly meetings with other Iranian mental health NGOs in order to share experiences and ideas. These meetings had a significant effect on the quality of the services provided by those NGOs, as they have been receiving far much useful information about the available resources and facilities in their context.

providing scientific sessions at some universities in various occasions (e.g., international day of schizophrenia, international day of mental health, international day of occupational therapy and so on);

collaborating with important organizations, Ministry of Cooperative, Labor and Social Welfare, Ministry of Health, Welfare organization and others. As a result, Iran WAPR received an approval for revising the "Iranian mental health act" and also for modifying the current disability insurances. This is a core moment, since several general hospitals have been integrating psychiatric rehabilitation services into their programs;

finally, the branch is working in detecting the potential for non-mental health organizations to be involved and activated in favour of mental health and inclusion of people with mental illnesses.

National and regional festivals for mental health clients, like sport and music festivals were organized, strongly emphasizing the importance of the quality of these programs and also trying to increase their frequency in the coming year.

A session was held with Dr Javed, WAPR past-president, in October 2015 in Tolou center of psychiatric rehabilitation. During this session, Iran WAPR described its activities and services. Also, members talked about their concerns and plans with Dr Javed and received many positive feedbacks and useful comments from him.

(Received from President Dr Hamid Taherkhani and secretatry Dr Mitra Khalaf Beigi)

**Spanish Federation of Associations for Psychosocial Rehabilitation (FEARP)**

The board of directors of the FEARP usually holds three face-to-face yearly meetings in different cities in Spain. In 2015 the meetings were held in Las Palmas de Gran Canaria and Madrid while the General Assembly was held in Valencia. Between meetings there are frequent communications through a Google group.

The main subjects that were debated in the last year are:

The opening in Valencia of the State Reference Centre (CRE) of Care for Persons with Severe Mental Disorder by a Social Service Agency
(IMSERSO) has generated significant internal controversy (partnership or no partnership with the CRE) on what different role should be played by health and social agents in psychosocial rehabilitation. The FEARP has formalised a written statement defending coordinated action in all areas and always within a community care model.

The care model in psychosocial rehabilitation is a traditional debate within the FEARP. In Spain there is neither a unified model on rehabilitation care or on responsibility from health and social services respectively. There is an autonomous organization in each region. The FEARP participated in several documents with proposals for a model (for example the “Care Model for Persons with Severe Mental Disorder”); these proposals must be updated constantly, according to what established in our last meeting.

The Observatory of Psychosocial Rehabilitation in Spain of the FEARP has encountered many difficulties due to the heterogeneity of rehabilitation structures in different territories. It is an organisational chaos that has led the persons in charge of the Observatory (F. Villegas) to split up the activity by areas in the Working Groups of the FEARP where the task may be easier to accomplish.

The Working Groups of the FEARP represent areas of high interest within the psychosocial rehabilitation field. There are three groups that develop studies and specific documents: Vocational, Residential and Human Rights. For 2016 a fourth Working Group on the importance of including the gender perspective in psychosocial rehabilitation was proposed.

The “Psychosocial Rehabilitation Journal” of the FEARP is the flagship publication of this topic in Spanish-speaking regions globally. Its last published issue was Volume 12 and is accessible freely and free of cost online from http://www.fearp.org/revista.

The Committee of Users, led by Pedro Pibernat, promotes contact with the associative movements of users, participates in forums of associations of users and family members and it has coordinated their participation in our V National Conference in Valencia. This represents an important line of activity for the FEARP.

The FEARP participates in the WAPR mainly with the work of Ricardo Guinea together with the support of other fellows, such as Begoña Frades, who attended the meeting of the WAPR in Turin on 15 and 16 May 2015 on behalf of the FEARP.

The FEARP has adhered to the Declaration of the WARP Europe on the asylum crisis in Europe.

In the 12th World Conference of the WAPR held in Seoul in November 2015 it was confirmed that Spain will host the conference of the WAPR in 2018. To this end have begun the preparations.

FEARP participation in the Technical Drafting Committee of the Mental Health Strategy of the National Health System through our representatives Martín Vargas and Begoña Frades is an important boost to the development of strategic plans based on psychosocial rehabilitation.

The third edition of the Master in Psychosocial Rehabilitation in Community Mental Health (October 2014 – September 2015) took place and the fourth edition was started from the University Jaume I. This online master is supported by FEARP in collaboration with other entities (AEN, FEAFES, etc.) where professionals from different Spanish-speaking countries are trained. http://www.uji.es/ES/infoest/estudis/postgrau/oficial/e@/22891/?pTitulacionId=42151

The FEARP maintains a policy of collaboration with related entities. Ricardo Guinea attended on behalf of the FEARP the Memorial Day of the World Mental Health Day “Put yourself in my place. Connect with me”, organised by the Mental Health Spain Confederation on 6 October in Madrid. He was also representing the FEARP in the XXVI Conference of the AEN, etc.

The FEARP website displays FEARP activity and interests. It publishes information of interest in the field of psychosocial rehabilitation. http://www.fearp.org

The V Conference of the FEARP in Valencia held on 1, 2 and 3 October 2015 is the culmination of two years of organisation of our fellows in Valencia led by Begoña Frades. Within the Conference we find professionals, users and family members exchanging impressions, views and good moments of relaxation and leisure. All of it is essential for good mental health and recovery of everyone, all users, family members and professionals.

(Received from Monica Garcia and Jaime A Fernández)

WAPR Italy

On the 15-16 May 2015 was held in Turin the Fifth WAPR European Congress "Mental health and physical health in a changing Europe". Five hundreds people participated from all over Europe.
With the leading action of the President, Prof Massimo Casacchia, WAPR Italy contributed to the intense debate around the closure of forensic hospitals and the implementation of new types of facilities for offenders. A paper was published in 2015, “Il superamento degli ospedali psichiatrici giudiziari: a new deal per la salute mentale?” (Closure of Italian psychiatric forensic hospitals: a new deal for mental health?) Casacchia et al., “Rivista di Psichiatria” 2015, 50(5):199-209.

The branch also issued a position paper about involuntary admissions and involuntary admission procedures, after a few events where patients died during their involuntary admissions. The document, in Italian, can be found in www.wapr-italia.it.

Several sponsorships for events were asked and allowed in the last years: “Update about psychopharmacological treatment for users and family members” Milan, 3 June 2014; “Prevention of risk of psychopathologies in the siblings of psychiatric patients” Milan, 27 February 2015, and to the course “Protagonisti del proprio benessere. Percorsi di Recovery” (“Leading actors of our own wellbeing. Ways to Recovery”) consisting of six sessions and financed by the City of Milan, 2015-2016.

In collaboration with several consumers and family associations, and with the IRCCS Istituto di Ricerche Farmacologiche Mario Negri, Milan, WAPR has started a survey of the activities addressing the physical health of users, with specific attention to young users in the mental health services of the Milan area. Data collection is almost complete and the research design, possibly with some preliminary findings, will be presented at the International Symposium on Promoting Recovery of Young People with Psychosis. The iFEVR and iphYs Joint Meeting in Milan 2016, 19 October 2016.

Several coordinated interventions will be presented at the IEPA Congress in Milan 20-22 October 2016.

A national congress has been scheduled for April 2017 to be held in Cesena.

The number 0 of the WAPR newsletter was issues in 2016. It seems to be a dissemination tool of WAPR mission and activities, also encouraging regular applications to the association.

Several Board meetings have been held in 2015 and 2016, the last ones on January 11 and June 23, 2016.

(Received from Barbara D’Avanzo, WAPR National Secretary)
### EXECUTIVE COMMITTEE

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